C

GROUP CONTINUATION COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT "COBRA"
PERS-HBD-85 (Rev 5/89)

PERS USE ONLY – DOCUMENT REFERENCE NUMBER

PUBLIC EMPLOYEES' RETIREMENT SYSTEM
Office of Employer and Member Health Services
P.O. Box 942714
Sacramento, CA 94229-2714
(888) CalPERS (225-7377)
TDD - (916) 795-3240 FAX (916) 795-1277

INSTRUCTIONS FOR COMPLETING THIS FORM ARE ON THE REVERSE SIDE. ***PLEASE TYPE***

PART A: ORIGINAL QUALIFYING EVENT AND DATES

1. Type of Action	2. QUALIFYING EVENT	3. EVENT DATE	4. COBRA ENROLLMENT PERIOD
☐ NEW ☐ Change	☐ EMPLOYMENT SEPARATION/TIMEBASE REDUCTION ☐ DIVORCE/LEGAL SEPARATION ☐ CHILD CEASES TO BE A DEPENDENT ☐ DEATH OF AN EMPLOYEE/RETIREE ☐ DEPENDENT CONTINUATION – ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE		FROM ____ 01 ____ TO ____

PART B: ENROLLEE INFORMATION

5. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER)	6. SUBSCRIBER (EMPLOYEE/RETIREE)
SOCIAL SECURITY NUMBER ___ ___	SOCIAL SECURITY NUMBER ___ ___
NAME	NAME
ADDRESS	
CITY, STATE, ZIP	
Day Phone ( )	Married ☐ Yes ☐ No
BIRTHDATE	SEX ☐ MALE ☐ FEMALE

PART C: CARRIER INFORMATION

7. NAME AND ADDRESS OF HEALTH PLAN

PLAN CODE:_____ PREMIUM: $_____

PHONE:

PART D: DEPENDENT INFORMATION

ACTION CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN: (FIRST) (MI) (LAST)	DATE OF BIRTH MO.	DAY	YR	FAMILY RELATION SHIP
					SELF

PART E: ENROLLMENT CHANGES

9. NAME OF PRIOR HEALTH PLAN	11. PERMITTING EVENT CODE	12. PERMITTING EVENT DATE	13. EFFECTIVE DATE OF CHANGE
10. PRIOR PLAN CODE			01

PART F: ELECTION CERTIFICATION

14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.

_____ _____

SIGNATURE OF COBRA ENROLLEE (SEE REVERSE FOR PRIVACY INFORMATION) DATE SIGNED

PART G: AGENCY INFORMATION

15.
AGENCY NAME _____

AGENCY CODE _____ UNIT CODE _____

16. HEALTH BENEFITS OFFICER'S SIGNATURE

_____

PHONE ( ) _____ DATE RECEIVED _____

PRIVACY INFORMATION

Submission of the requested information is mandatory. The information requested is collected pursuant to the Government Code Sections (20000. et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to another governmental agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229-2702.

INSTRUCTIONS FOR THE COMPLETION OF FORM HBD-85 (11/04)

Part A: 1. Type of Action. Check "new" if this is a new enrollment.
Check "change" if family member is added, deleted, or for plan changes.
2. Check applicable original qualifying event.
3. Provide original event date (separation, date of divorce, etc.).
4. Original COBRA enrollment period. Examples:
Separation from employment 4-15-89 (Perm. Event) FROM 6-1-89 TO 11-30-90
Child attains age 23 on 6-15-89 (Perm. Event) FROM 7-1-89 TO 6-30-92

Part B. 5. Please provide all requested information.
6. If the COBRA enrollee is a former dependent, the employee/retiree must be identified in Box 6.

Part C. 7. Please identify the carrier. The COBRA enrollee must continue the same coverage which he or she had as an employee or as a dependent. Carrier changes are only allowed during the open enrollment period of if the enrollee moves into or out of a carrier's geographic service area. The carrier's name, address, phone number, plan code, and premium can be found in the annual "Health Plan Decision Guide" which is available in all employing agencies. The monthly premium may not exceed 102% of the group rate.

Part D. 8. List all family members to be enrolled, including self.
Action Code: Use "A" to indicate which person is being added (or newly enrolled).
Use "D" to indicate individual is being deleted from an existing COBRA enrollment
An Action Code is not required when changing carriers.
IMPORTANT: The addition or deletion of family members is regulated by time limits which are identical to those for active enrollees (subscribers).

Part E. 9-10. Name and plan code of prior health plan, if COBRA coverage is being changed
10-13. To be completed by the Health Benefits Officer.

Part F. 14. Signature of COBRA enrollee and date signed.

Part G. 15-16. To be completed by the (former) employing agency. For former dependents of retirees, PERS is the "employing agency."

IMPORTANT: It is the responsibility of the COBRA enrollee to report enrollment changes in a timely manner. Enrollment change requests must be submitted in accordance with existing regulations, laws, and the time limits applicable to the Public Employees' Medical and Hospital Care Act. All change requests are directed through the agency listed in Part G.